Office of Health Equity Veterans Health Administration Department of Veterans Affairs



IDENTIFYING AND ADDRESSING HEALTH-RELATED SOCIAL NEEDS AMONG VETERANS FACT SHEET

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INTRODUCTION

The Veterans Health Administration (VHA) serves a Veteran population that is increasingly racially and ethnically diverse and rapidly aging. Equitable access to high-quality care for all Veterans is a major tenet of the VA healthcare mission. The Office of Health Equity (OHE) champions the elimination of health disparities and achieving health equity for all Veterans.

HEALTH-RELATED SOCIAL NEEDS

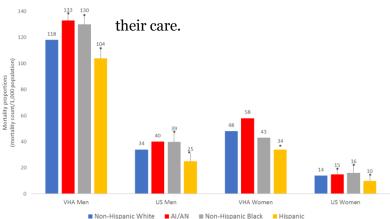
Health care access is not the only determinant of health outcomes. Often minority populations face barriers in their neighborhoods like food insecurity, housing instability, transportation challenges and a lack of employment opportunities. These health-related social needs can result in poor health care access and health outcomes.

VHA is an equal-access health care system that is unique in that it does not require users to pay insurance premiums to access care. Additionally, VHA works to address health-related social needs of the Veterans it serves by providing transportation assistance, extended clinic hours and other services and referrals to address health-related social needs.

ADDRESSING HEALTH DISPARITIES IN HEALTH CARE DECISION MAKING

The efforts VHA are making to address health-related social needs appear to be helping to reduce health disparities when mortality rates of Veterans are compared to non-Veterans. While there are still racial/ethnic disparities amongst VHA-users, many differences are smaller than those in the U.S. general populations. Additionally, in the general population, non-Hispanic Black women have an 11% increase in risk of dying than non-Hispanic White women. However, this has not been observed among women Veterans using VHA for

Number of Deaths per 1,000 People By Race/Ethnicity for Men and Women Veterans and the U.S. general populations, accounting for population age composition differences



* Denotes statistically significant difference from the non-Hispanic Whites within the sex-stratified VHA or US population Note: Differences in age composition between the VHA and U.S. general populations are accounted for through the direct standardization methods, where mortality proportions have been standardized using weights based on the FY 2009 non-Hispanic White men or female VHA-use population.



REDUCING DISPARITIES AND IMPROVING ACCESS TO CARE

The Office of Health Equity supports national and local efforts by the VA to reduce health disparities among vulnerable populations, including the VA New England Healthcare System's (VISN 1) healthrelated social needs (HRSN) and resource referral program. This program screens Veterans for health-related social needs and provides local resource referrals at the point of care by. Veterans are asked to complete a 12-question health-related social needs assessment that encompasses nine domains: education; employment; exposure to abuse and violence; food insecurity; housing instability; legal needs; social isolation; transportation needs; and utility needs. Upon completion of the assessment, Veterans are provided with resource guides based on their identified need(s) and location.

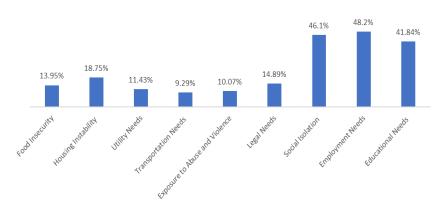
Screening results become a part of a Veteran's electronic health record (EHR) and are available immediately by the Veteran's clinical care team. This ensures that Veterans are screened for risk factors like homelessness and food insecurity at future medical appointments.

BEDFORD VA MENTAL HEALTH EVALUATION CENTER PILOT

In October 2018, the health-related social needs assessment and resource referral program was

piloted at the Edith Nourse Rogers Memorial Veterans Hospital in Bedford, Massachusetts. Among the 141 Veterans screened so far, 82% of Veterans reported at least one unmet health-related social need, and 29% of Veterans reported three or more.

Health-related Social Needs Among Veterans in the Bedford HRSN and Resource Referral Program Pilot



This pilot is expanding to two additional sites in the VA Boston Healthcare System. The expanded pilot will be evaluated to determine: 1) the feasibility of integrating eScreening across multiple VA sites; 2) the prevalence of health-related social needs and sociodemographic characteristics associated with screening positive for these needs; and 3) the major barriers to addressing identified needs. Results will be used to determine the most effective ways to screen for and address Veterans' health-related social needs across VHA.

For more information about the Office of Health Equity visit: https://www.va.gov/healthequity/